



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
**MO HEALTHNET APPLICATION/ELIGIBILITY
STATEMENT**

FOR OFFICE USE ONLY

DATE APPLIED

<input type="checkbox"/> QUALIFIED MEDICARE BENEFICIARY	<input type="checkbox"/> MO HEALTHNET FOR THE AGED, BLIND, AND DISABLED	DCN #1	DCN #2
<input type="checkbox"/> SPECIFIED LOW INCOME MEDICARE BENEFICIARY	<input type="checkbox"/> SPENDDOWN	ELIGIBILITY SPECIALIST/SUPV/LOAD / /	
<input type="checkbox"/> SUPPLEMENTAL NURSING CARE	<input type="checkbox"/> NON-SPENDDOWN		
<input type="checkbox"/> BLIND PENSION	<input type="checkbox"/> VENDOR		
<input type="checkbox"/> SUPPLEMENTAL AID TO THE BLIND			

APPLICANT NAME (FIRST, MIDDLE, LAST)

ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P. O. BOX)

CITY, STATE, ZIP CODE

HOME PHONE NUMBER

WORK PHONE NUMBER

MESSAGE PHONE NUMBER

I, the above named applicant, under the laws of the state of Missouri, hereby apply for:

- ☐ MO HealthNet for the Aged, Blind, and Disabled
☐ Payment of Medicare Premiums

- ☐ Nursing Home Assistance
☐ Cash Assistance for the Blind

Below, list your name first, then all other persons who live with you.

NAME (FIRST, MIDDLE, LAST)	NAME (MAIDEN)	HISPANIC Y/N	RACE/ SEX	RELATIONSHIP (SPOUSE, SON, SISTER, FRIEND)	BIRTHDATE	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	CHECK (✓) FOR WHOM APPLYING
				SELF				✓

*1. CAUCASIAN 2. BLACK/AFRICAN AMERICAN 4. AMERICAN INDIAN/ALASKA NATIVE 5. ASIAN 6. NATIVE HAWAIIAN/PACIFIC ISLANDER

1. Are all of the persons applying U. S. citizens? ☐ YES ☐ NO If no, list the following information for applicants listed above who are not U. S. citizens: Name, immigration status, registration number, and date of entry:

2. I/We are residents of Missouri and intend to remain. ☐ YES ☐ NO

3. The reason I/we are applying check (✓) all that apply.

- ☐ Age 65 or over ☐ Blind ☐ Disabled ☐ Unable to work due to a physical or mental illness
☐ I/We need help paying my/our Medicare premiums.
☐ I reside in or plan to enter a nursing home/facility.

4. If you are a resident of a nursing facility and wish to give part of your income to your spouse or a dependent relative, list the name(s):

5. Are you living in or supported by a public, medical, or private facility? ☐ YES ☐ NO
Facility Name

6. You may qualify for coverage of unpaid bills for medical services received in the past three months. Would you like us to explore your eligibility for the last three months? ☐ YES ☐ NO

COMPLETE THIS SECTION IF YOU ARE UNDER AGE 65 AND NOT RECEIVING SOCIAL SECURITY DISABILITY AND/OR SUPPLEMENTAL SECURITY INCOME. PLEASE LIST ALL SOURCES YOU WISH CONTACTED TO PROVIDE A FULL AND ACCURATE STATEMENT OF YOUR MEDICAL HISTORY AND CONDITION.

DOCTORS, HOSPITALS, CLINICS, OTHER

NAME	ADDRESS
NAME	ADDRESS

7. Have you or your spouse ever served in the U. S. Military? ☐ YES ☐ NO

EMPLOYMENT

1. Are you now employed? ☐ Yes ☐ No

If yes, name of employer _____.

Amount you are paid before deductions \$ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice monthly ☐ Monthly

2. Is anyone else in your home employed? ☐ YES ☐ NO

If yes, who? _____.

Amount they are paid before deductions \$ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice Monthly ☐ Monthly

3. Does anyone in your home operate their own business or are they otherwise self-employed ☐ YES ☐ NO

If yes, list who, describe what type of self-employment (babysitting, farm income, other) and amount earned:

_____.

OTHER INCOME

I/We receive other income from the following. Check (✓) all that apply.

	RECEIVED BY	SOCIAL SECURITY CLAIM NUMBER	AMOUNT PER MONTH
<input type="checkbox"/> Social Security			
<input type="checkbox"/> Supplemental Security Income			
<input type="checkbox"/> Trust Funds/Annuities			
<input type="checkbox"/> Pensions/Retirement/Disability			
<input type="checkbox"/> Interest or Dividends			
<input type="checkbox"/> Veteran's Benefits			
<input type="checkbox"/> Unemployment Compensation			
<input type="checkbox"/> Assistance from friends or relatives			

☐ Other: Explain where the money comes from and the amount.

INSURANCE

I/We have Medicare. ☐ YES ☐ NO If yes, list name(s) _____

I/We have other health insurance. ☐ YES ☐ NO If yes, complete the following:

PERSON INSURED	INSURANCE COMPANY	POLICY NUMBER	TYPE OF COVERAGE

I/We have life insurance and/or burial plans. ☐ YES ☐ NO If yes, complete the following:

PERSON INSURED	POLICY OWNER	CHECK (✓) KIND LIFE BURIAL	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE

I/We have the following cash, securities, or personal property. Check (✓) all that apply.

CASH AND SECURITIES		IN WHOSE NAME	LOCATION	VALUE
<input type="checkbox"/>	Checking Accounts/Joint Checking Accounts Account Numbers:			
<input type="checkbox"/>	Savings Accounts/Joint Savings Accounts, Christmas Club Savings, Certificates of Deposit, Credit Union, IRA, Deferred Compensation Account Numbers:			
<input type="checkbox"/>	Patient accounts at a nursing home or other institution			
<input type="checkbox"/>	Cash on hand			
<input type="checkbox"/>	Stocks, bonds, or other investments			
<input type="checkbox"/>	Notes or mortgages owed to you			
<input type="checkbox"/>	Property held in a Safe Deposit Box (state location and contents of box).			

PERSONAL PROPERTY		LOCATION	VALUE	DEBT
<input type="checkbox"/>	Burial lots			
<input type="checkbox"/>	Household furniture (not in use)			
<input type="checkbox"/>	Housetrailer			
<input type="checkbox"/>	Jewelry (other than wedding and engagement rings, watches, or costume jewelry)			
<input type="checkbox"/>	Business equipment			
<input type="checkbox"/>	Farm machinery, livestock, grain, and/or produce			
<input type="checkbox"/>	Property claims in Probate Court			
<input type="checkbox"/>	Other (explain)			

VEHICLES – List cars, trucks, vans, motorcycles, recreational vehicles, and others.

MAKE/MODEL	YEAR	OWNER	VALUE	DEBT	HOW IS IT USED?

REAL PROPERTY

I/We own or are buying real estate. ☐ YES ☐ NO

LIST KIND AND LOCATION	WHOSE NAME IS ON THE DEED?	CURRENT VALUE	AMOUNT OWED	HOW IS IT USED? (HOME, RENTAL, ACREAGE, OTHER)

TRANSFER OF PROPERTY/RESOURCES

1. Has anyone in your home sold or given away any money, vehicles, property, or any other resources within the last five years? ☐ YES ☐ NO If yes, complete the following:

What?

When?

To whom?

Why?

Amount received \$

2. Have you or your spouse created, or been a party of, a Trust Estate within the last five years? ☐ YES ☐ NO

If yes, explain

COMPLETE IF APPLYING FOR CASH ASSISTANCE FOR THE BLIND

1. Do you have a sighted spouse or parent? ☐ YES ☐ NO

2. Do you solicit alms? ☐ YES ☐ NO

3. Have you applied or do you agree to apply for Supplemental Security Income (SSI) as a condition of eligibility? ☐ YES ☐ NO

4. Have you had eye surgery within the last five years? ☐ YES ☐ NO

5. If you are under age 75, are you willing to have medical treatment or an operation to correct blindness? ☐ YES ☐ NO

6. If recommended, are you willing to accept vocational training or work at an occupation for which you are suited? ☐ YES ☐ NO

IF YOU HAVE A CHECKING OR SAVINGS ACCOUNT, YOU CAN HAVE YOUR CASH ASSISTANCE DEPOSITED DIRECTLY INTO YOUR ACCOUNT.☐ I want direct deposit.☐ I do not want direct deposit.**PLEASE READ CAREFULLY AND SIGN BELOW**

I/We UNDERSTAND that I/we are entitled to fair and equal treatment regardless of age, sex, race, color, handicap, religion, creed, national origin or political belief.

I/We UNDERSTAND if I/we disagree with the decision concerning our eligibility, I/we may request a fair hearing by contacting the local Family Support office. This request must be received within 90 days of the eligibility decision.

I/We UNDERSTAND that I/we must provide Social Security Numbers (SSN) of all persons applying for MO HealthNet. The SSN is used to determine eligibility and verify information (Section 1137 of the Social Security Act).

I/We authorize the Director of Family Support Division or his/her appointee to investigate and verify these circumstances and statements.

I/We UNDERSTAND that I/we must report any changes in circumstances within ten days of when they happen.

I/We UNDERSTAND that it is against the law to obtain or attempt to obtain benefits to which I/we are not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.

I/We UNDERSTAND that the State of Missouri may file a claim against my/our estate to recover any assistance received. This does not apply to Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary programs.

I/We UNDERSTAND that I/we must provide complete information regarding any health or accident insurance benefit available to any household member and I/we must report within 30 days any accident for which medical care is received.

I/We hereby authorize all providers of medical benefits who render services or merchandise to me/us under MO HealthNet to release all records regarding such services or merchandise to the Department of Social Services and its representatives.

I/We UNDERSTAND that application for and acceptance of MO HealthNet constitutes an assignment of rights to the Department of Social Services, MO HealthNet Division for payment for medical care from a third party.

Provided I/we are found to be eligible for assistance, I/we wish payments by the MO HealthNet Division and/or the Title XVIII medical insurance program to be made directly to physicians and medical suppliers on any future covered unpaid bills for medical and other health Services furnished me/us while eligible for MO HealthNet.

My/our signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete.

SIGNATURE OF APPLICANT

DATE

SIGNATURE OF SPOUSE

DATE